STATE OF CALIFORNIA

RURAL HEALTH CARE EQUITY PROGRAM (RHCEP) CLAIM FORM

DPA 678 (REV.12-07)

All requests for reimbursement under the RHCEP for each fiscal year (ending June 30th) must be received by Application Software, Incorporated (ASI) no later than the following September 15th.

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM BEFORE COMPLETING. PLEASE PRINT IN INK OR TYPE.

I. EMPLOYEE/RETIREE INFORMATION

REIMBURSEMENT FOR SERVICES RENDERED WHILE ACTIVE AND REIMBURSEMENT FOR SERVICES RENDERED WHILE RETIRED MUST BE LISTED ON SEPARATE CLAIM FORMS. SEPARATE CLAIM FORMS MUST ALSO BE USED FOR SERVICES INCURRED DURING EACH PLAN YEAR.

SUBSCRIBER STATUS AT TIME OF SERVICE (Check one)	RURAL SUBSIDY PLAN YEAR (Check one)	
☐ Active ☐ Retired	☐ Plan Year 07/08 **(7/1/07 - 6/30/08)**	☐ Plan Year 08/09 **(7/1/08 - 6/30/09)**
LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER
MAILING ADDRESS	CITY, STATE, ZIP CODE	DAYTIME PHONE (Include area code) ( )

II. OUT-OF-POCKET MEDICAL EXPENSES TO BE REIMBURSED

LIST EXPENSES BY DATES SERVICES WERE INCURRED. SEE BACK OF FORM FOR DEFINITIONS.

ITEM NO.	(a) NAME OF PATIENT	(b) RELATIONSHIP TO SUBSCRIBER (self, spouse, child)	(c) DATE SERVICES INCURRED	(d) DEDUCTIBLE (active or retired)	(e) CO-INSURANCE (active employees only)	ASI USE ONLY
1				$	$	
2				$	$	
3				$	$	
4				$	$	
5				$	$	
6				$	$	
7				$	$	
8				$	$	
9				$	$	
10				$	$	
TOTAL REIMBURSEMENT AMOUNT REQUESTED (SUM OF COLUMNS D AND E)				$		

Attach a copy of the Explanation of Benefits (EOBs) to support each item listed above. Please arrange EOBs in same order as listed above and send along with this form to the address below. Retain a copy for your records.

III. EMPLOYEE/RETIREE STATEMENT — READ CAREFULLY

I certify that all expenses claimed on this form were incurred during the period while I was eligible to participate in the RHCEP. I certify that the amounts claimed have not been submitted for reimbursement under any other health care plan or program, federal, state or governmental program, workers' compensation, or any other policy of health insurance including the State of California FlexElect Medical Reimbursement Account. I acknowledge that I am fully responsible for the accuracy and validity of all information relating to this claim and my signature to this effect is required below.

EMPLOYEE/RETIREE SIGNATURE REQUIRED	DATE
✍	

Send completed RHCEP Claim Form with copies of supporting EOB(s) to:

ASI
P.O. Box 657
Columbia, MO 65205-0657

Customer Service: 1-800-659-3035
Business Hours: 8 a.m. to 5 p.m. Pacific Standard Time
Email: asi@asiflex.com

Use your PIN (available from ASI) to access your account on-line at http://asiflex.com/flexreports (account detail).

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS

STATE OF CALIFORNIA

RURAL HEALTH CARE EQUITY PROGRAM (RHCEP)
CLAIM FORM

DPA 678 (REV. 12-07)

PRIVACY STATEMENT

It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in RHCEP reimbursements not being processed or being processed incorrectly.

The RHCEP administrator requires subscriber's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Section 22877 and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Copies of the RHCEP reimbursement claim form are maintained in confidential files of the RHCEP third party administrator for five years. Employees have the right of access to copies of their RHCEP reimbursement claim forms upon request. The official party responsible for access of this form is ASI, P.O. Box 657, Columbia, MO 65205-0657, Telephone Number 1-800-659-3035.

CLAIM FILING INSTRUCTIONS

SECTION I

Check "Active" or "Retired." Reimbursement for services rendered while active and reimbursement for services rendered while retired must be listed on separate claim forms. Check appropriate plan year. Separate claim forms must also be used for services incurred during each plan year. Print subscriber's name, address, Social Security Number and your daytime phone number (include area code).

SECTION II

List expenses by the date services were incurred and arrange the supporting Explanation of Benefits (EOBs) in the same order. Highlight or circle the service dates on your EOBs. If you have several EOBs for the same family member, you may subtotal them and list them as one item with a range of dates. Eligible providers are PERSCare, PERS Choice, PERS Select, PORAC, CCPOA and CAHP.

(a) Name of Patient – List the name of person who obtained medical services.

(b) Relationship to Subscriber – If other than self, describe relationship to subscriber if dependent has received services.

(c) Date Services Incurred – Date service(s) was rendered by medical provider (not the date of payment).

(d) Deductible – Amount of eligible out-of-pocket medical expenses that State employee/retiree is claiming for reimbursement. Both retirees and active employees are entitled to reimbursement of deductible expenses. The amount that can be claimed is shown on the EOB under the "DEDUCTIBLE AMOUNT" column.

(e) Co-insurance – The co-insurance amount that can be claimed is shown on the EOB under column titled "COPAYMENT AMOUNT." Only active employees are entitled to reimbursement of co-insurance expenses. Co-payment expenses shown under the "COPAYMENT AMOUNT" column on the EOB are not eligible for reimbursement.

Total Reimbursement Amount Requested - Add amounts in columns D and E and list the total sum.

SECTION III

Read the Employee/Retiree Statement carefully, then sign and date the claim form. Please make a copy for your records. Mail claim form and copies of EOBs to ASI at the address shown on the front of this form.

IMPORTANT: A copy of the EOB is required to process claims. Contact Blue Cross at 1-877-737-7776 or on-line at www.bluecrossca.com to obtain a duplicate copy.

DEFINITIONS

ASI: The Third Party Administrator for the RHCEP.

Co-Insurance: The cost sharing by the health plan and State employee/retiree of eligible hospital or medical expenses at a specified ratio.

Co-payment: The amount paid for each medical service. A co-payment is usually a fixed amount State employee/retiree pays for services, such as $10 or $20.

Deductible: The annual amount of out-of-pocket medical expenses that State employee/retiree must pay before the health plan begins paying for expenses.

Explanation of Benefits: The statement provided by your health plan after you receive medical care.

Plan Year: The RHCEP Plan Year corresponds to the State's fiscal year. Plan Year 07/08 is July 1, 2007, through June 30, 2008 and Plan Year 08/09 is July 1, 2008, through June 30, 2009.

Subscriber: State employee/retiree who meets RHCEP criteria.

ELIGIBLE EXPENSES

Active employees may claim reimbursement of qualifying expenses up to $1,500 per plan year. Co-payment and dental expenses do not qualify.

Retirees who are not enrolled in Medicare Parts A & B are entitled to claim reimbursement of their annual deductible only, up to $500 for an individual, two-party or family enrollment.